ATTORNEY PAYMENT REQUEST
(Revised 12-17-15)

Case Caption _____ vs_____
Plaintiff or ("Depo Rep") Defendant(s)(Health Care Provider(s))

Your invoice # _____ Date of invoice _____ HCSF No. _____

Attorney Name _____

Firm Name _____

Firm Billing Address_____
(Street or PO Address, City, State, Zip) (this is where check will be mailed)

Address Check to be mailed to: _____

Your billing contact: Name_____

Phone _____ Email _____

Special Instructions:

****

For HCSF Use Only: Authorized by: _____ Date: _____ Atty #: _____

Total Attorney Hourly Fees (F) _____

Total Attorney Travel Expenses (E) _____

Total Attorney Charges: $_____ Case No: _____ Case Letter: _____

_____	_____	_____	_____
Defendant) ( )	Defendant ( )	Defendant ( )	Defendant ( )
(F)_____	(F)_____	(F) _____	(F) _____
(M)_____	(M) _____	(M) _____	(M)_____

_____ KU Foundation _____KU Residency _____WCGME